Exhibit A

Abington Memorial Hospital

History & Physical

Summary 02/22/2012 00:00 through 02/22/2012 23:59

HP

Permanent Chart Copy

DCOBV	STRIMBER, ABRAHAM		MM__
MR#: 0482935	FIN#: 1205350964	DOB: 11/14/1950	AdmitDate: 02/22/2012
DR: Watson, Robert		Age: 61y	Service: Observation

History & Physical

***** This Document Has Been Modified *****

Originally Created:2/22/2012 4:09:00 PM
By: Turner, Margo (MD)

SERVICES:

- Div/Dept — Internal Medicine

CHIEF COMPLAINT:

.:

Chief Complaint: chest / epigastric / back pain , n/v/d
History Source: patient, spouse

HISTORY OF PRESENT ILLNESS:

.:

HPI: Patient is a 61 year old man who is s/p valve replacement surgery (avr & ?? mvr) who presents to ER for e/o legs vibrating and abdomen feeling like it is going to explode. Pt reports that abdominal pain is mid epigastric, pt had one episode of diarrhea yesterday and has vomited once in ER.
Pt describes eating radishes, tomatoes , eggs and lox today and feeling these symptoms after that.
Pt had non contrast ct abd in ER and is admitted for further evaluation and management.

MEDICATIONS TAKEN AT HOME (entered in Sunrise Med Rec):

Warfarin.., mg, PO, DAILY (2100); patient dose varies between 5 and 7.5 mg daily depending on inr results , 22-Feb-2012, Historical
Metoprolol, (. LOPRESSOR) Tablet\par 12.5 mg, ORAL, DAILY, 22-Feb-2012, Historical
Multivitamin Therapeutic, Tablet\par 1 tablet(s), ORAL, DAILY, 22-Feb-2012, Historical

ALLERGIES:

- Iodinated contrast: Z_Anaphylaxis
- Iodinated radiocontrast dyes: Undefined
- IVP dye: Undefined
- Iodinated radiocontrast agents: Z_Entered brand

REVIEW OF SYSTEMS:

Comments:

.: All other system are noncontributory.

PHYSICAL EXAM TEXT:

Physical Exam Text:

Physicial Exam Text: vs : bp 131/59 p 70 r 18
heart : s 1 & s 2 in rr
lungs : bs + both lung fields
abd : nabs, soft, non tender, no cvat

ext : no e / no p
neuro : non focal examination

LAB RESULTS:

22-Feb-2012 12:37

PTT.	40
Glucose (Random)	141
BUN	14
Creatinine	1.32
Sodium Level	141
Potassium	3.7
Chloride	105
Carbon Dioxide	23
Anion Gap	17
AST	26
ALT	18
Alkaline Phosphatase	68
Calcium Level	8.9
Albumin	4.3
Total Protein	6.6
Calculated GFR	55
GFR African American	>60
Bilirubin,Total	0.5
CK w/Reflexive MB	161
INR	2.8
WBC	12.1
RBC	5.02
Hemoglobin.	15.0
Hematocrit	43.8
Platelets	192
MCV	87.4
MCH	29.9
MCHC	34.2
RDW	12.7

MPV	8.1
Neutrophils	80
Lymphs	11
Monocytes	8
EOS.	1
Basos	0
Absolute Neutro	9.7
Absolute Mono.	1.0
Absolute EO	0.1
Absolute Baso.	0.0
Absolute Lymph.	1.3

OTHER RESULTS:

Radiology Results:

Cat Scan:

22-Feb-2012 12:57, CT ABD/Pelvis W-O Contrast

CT ABD/Pelvis W-O Contrast: FINALCT ABD PEL W O CONTRASTHISTORY: Mid upper abdominal and back pain. TECHNIQUE: Helical axial images were obtained from the domes of the diaphragm through the pubic symphysis. Neither oral nor intravenous contrast was administered.Coronal and sagittal reformatted images were also evaluated. Comparison: None. FINDINGS: The patient is status post median sternotomy. The heart is enlarged. There is no pericardial effusion. There is dependent atelectasis at the lung bases posteriorly. Evaluation of the abdominal and pelvic organs is limited without intravenous contrast. The liver is unremarkable without evidence of solid mass or biliary ductal dilatation. The gallbladder is unremarkable in appearance. The spleen isnormal in appearance. The pancreas is unremarkable. The right adrenal gland is unremarkable. There is a subcentimeter low-attenuation nodule in the left adrenal gland which likely represents an adenoma. There are no abnormally enlarged mesenteric, retroperitoneal, pelvic, or inguinal lymph nodes. There is a small fat containing left inguinal hernia. The prostate gland is unremarkable. The urinary bladder is normal in appearance without focal mass or wall thickening. There is no bowel obstruction, bowel wall thickening, or free air. No free fluid is visualized. A normal appendix is visualized. No hydronephrosis or renal calculus is seen. There is a cystic lesion in the lower pole the left kidney, which is likely a simple cyst, however isincomplete characterized on this noncontrast examination. Repeat study with intravenous contrast and be helpful to better characterize the nature of this lesion. There is minimal aortoiliac atherosclerosis. There is no aneurysmal dilatation or evidence of dissection or rupture on this noncontrast study. There are mild scoliotic and degenerative changes of the spine. No destructive bony lesions are visualized. Impression: Somewhat limited study without intravenous contrast. Cystic lesion

in the left kidney is likely a simple cyst , however it is incompletely characterized without intravenous contrast. Ultrasound of the kidneys or CT scan with intravenous contrast would be helpful to better determine the nature of this lesion. No abdominal aortic aneurysm. No evidence of dissection on this noncontrast study. Cardiomegaly. Signed by: GOLDMAN, YEDIDA Signed on: 02/22/2012 13:31:31

PLAN COMMENTS:

Comments (Assessment and Plan): 1) chest / epigastric / back pain - nc ct abd done, telemetry, trend ce, ekg , anti emetics and analgesics
2) history of valve replacement surgery - inr 2.8, coumadin on hold as pt is npo - await further recommendations
3) n/v/d - npo, ivf, stool culture & stool for c. diff
Meds and plans as per orders.

Electronic Signatures:

Turner, Margo (MD) (Signed 22-Feb-2012 20:20)

Entered: SERVICES, CHIEF COMPLAINT, HISTORY OF PRESENT ILLNESS, MEDICATIONS TAKEN AT HOME (entered in Sunrise Med Rec), OMP, ALLERGIES, REVIEW OF SYSTEMS, PHYSICAL EXAM TEXT, LAB RESULTS, OTHER RESULTS, ASSESSMENT & PLAN, PLAN COMMENTS,
Authored: SERVICES, CHIEF COMPLAINT, HISTORY OF PRESENT ILLNESS, MEDICATIONS TAKEN AT HOME (entered in Sunrise Med Rec), OMP, ALLERGIES, REVIEW OF SYSTEMS, PHYSICAL EXAM TEXT, LAB RESULTS, OTHER RESULTS, ASSESSMENT & PLAN, PLAN COMMENTS
Last Updated: 22-Feb-2012 20:20

Edit History

HPI

Patient is a 61 year old man who is s/p valve replacement surgery (avr & ?? mvr) who presents to ER for e/o legs vibrating and abdomen feels like it is going to explode. Pt reports that abdominal pain is mid epigastric, pt had one episode of diarrhea yesterday and has vomited once in ER.
Pt describes eating radishes, tomatoes , eggs and lox [Originally Entered by: Turner, Margo (MD) on: 2/22/2012 4:28:30 PM]
Patient is a 61 year old man who is s/p valve replacement surgery (avr & ?? mvr) who presents to ER for e/o legs vibrating and abdomen feeling like it is going to explode. Pt reports that abdominal pain is mid epigastric, pt had one episode of diarrhea yesterday and has vomited once in ER.
Pt describes eating radishes, tomatoes , eggs and lox today and feeling these symptoms after that.
Pt had non contrast ct abd in ER and is admitted for further evaluation and management. [Changed to this value by: Turner, Margo (MD) on: 2/22/2012 8:20:12 PM]

Abington Memorial Hospital

History & Physical

Summary 02/22/2012 00:00 through 02/22/2012 23:59

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DCOBV	STRIMBER, ABRAHAM		MM__
MR#: 0482935	FIN#: 1205350964	DOB: 11/14/1950	AdmitDate: 02/22/2012
DR: Watson, Robert		Age: 61y	Service: Observation

Medications taken at home (entered in Sunrise Med

Warfarin.., mg, PO, DAILY (2100); patient dose varies between 5 and 7.5 mg daily depending on inr results, 22-Feb-2012, Historical [Selected by: Turner, Margo on: 2/22/2012 4:15:46 PM]

Metoprolol, (. LOPRESSOR) Tablet12.5 mg, ORAL, DAILY, 22-Feb-2012, Historical [Selected by: Turner, Margo on: 2/22/2012 4:15:46 PM]

Multivitamin Therapeutic, Tablet1 tablet(s), ORAL, DAILY, 22-Feb-2012, Historical [Selected by: Turner, Margo on: 2/22/2012 4:15:46 PM]

ALLERGIES

Iodinated contrast, Z_Anaphylaxis [Selected by: Turner, Margo on: 2/22/2012 4:15:46 PM]

iodinated radiocontrast dyes, Undefined [Selected by: Turner, Margo on: 2/22/2012 4:15:46 PM]

IVP dye, Undefined [Selected by: Turner, Margo on: 2/22/2012 4:15:46 PM]

Iodinated radiocontrast agents, Z_Entered brand [Selected by: Turner, Margo on: 2/22/2012 4:15:46 PM]

Abington Memorial Hospital

History & Physical

Summary 02/22/2012 00:00 through 02/22/2012 23:59

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DCOBV **STRIMBER, ABRAHAM** MM__

MR#: 0482935 FIN#: 1205350964 DOB: 11/14/1950 AdmitDate: 02/22/2012

DR: Watson, Robert Age: 61y Service: Observation

LAB RESULTS

22-Feb-2012 12:37

PTT. 40
Glucose (Random) 141
BUN 14
Creatinine 1.32
Sodium Level 141
Potassium 3.7
Chloride 105
Carbon Dioxide 23
Anion Gap 17
AST 26
ALT 18
Alkaline Phosphatase 68
Calcium Level 8.9
Albumin 4.3
Total Protein 6.6
Calculated GFR 55
GFR African American >60
Bilirubin,Total 0.5
CK w/Reflexive MB 161
INR 2.8
WBC 12.1
RBC 5.02
Hemoglobin. 15.0
Hematocrit 43.8
Platelets 192
MCV 87.4
MCH 29.9
MCHC 34.2
RDW 12.7
MPV 8.1
Neutrophils 80
Lymphs 11
Monocytes 8
EOS. 1
Basos 0
Absolute Neutro 9.7
Absolute Mono. 1.0
Absolute EO 0.1
Absolute Baso. 0.0
Absolute Lymph. 1.3
[Selected by: Turner, Margo on: 2/22/2012 4:15:46 PM]

Abington Memorial Hospital

History & Physical

Summary 02/22/2012 00:00 **through** 02/22/2012 23:59

HP

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DCOBV	**STRIMBER, ABRAHAM**		MM__
MR#: 0482935	FIN#: 1205350964	DOB: 11/14/1950	AdmitDate: 02/22/2012
DR: Watson, Robert		Age: 61y	Service: Observation

Radiology Results

CT ABD/Pelvis W-O Contrast, U, FINALCT ABD PEL W O CONTRASTHISTORY: Mid upper abdominal and back pain. TECHNIQUE: Helical axial images were obtained from the domes of the diaphragm through the pubic symphysis. Neither oral nor intravenous contrast was administered.Coronal and sagittal reformatted images were also evaluated. Comparison: None. FINDINGS: The patient is status post median sternotomy. The heart is enlarged. There is no pericardial effusion. There is dependent atelectasis at the lung bases posteriorly. Evaluation of the abdominal and pelvic organs is limited without intravenous contrast. The liver is unremarkable without evidence of solid mass or biliary ductal dilatation. The gallbladder is unremarkable in appearance. The spleen isnormal in appearance. The pancreas is unremarkable. The right adrenal gland is unremarkable. There is a subcentimeter low-attenuation nodule in the left adrenal gland which likely represents an adenoma. There are no abnormally enlarged mesenteric, retroperitoneal, pelvic, or inguinal lymph nodes. There is a small fat containing left inguinal hernia. The prostate gland is unremarkable. The urinary bladder is normal in appearance without focal mass or wall thickening. There is no bowel obstruction, bowel wall thickening, or free air. No free fluid is visualized. A normal appendix is visualized. No hydronephrosis or renal calculus is seen. There is a cystic lesion in the lower pole the left kidney, which is likely a simple cyst, however isincomplete characterized on this noncontrast examination. Repeat study with intravenous contrast and be helpful to better characterize the nature of this lesion. There is minimal aortoiliac atherosclerosis. There is no aneurysmal dilatation or evidence of dissection or rupture on this noncontrast study. There are mild scoliotic and degenerative changes of the spine. No destructive bony lesions are visualized. Impression: Somewhat limited study without intravenous contrast. Cystic lesion in the left kidney is likely a simple cyst , however it is incompletely characterized without intravenous contrast. Ultrasound of the kidneys or CT scan with intravenous contrast would be helpful to better determine the nature of this lesion. No abdominal aortic aneurysm. No evidence of dissection on this noncontrast study. Cardiomegaly. Signed by: GOLDMAN, YEDIDA Signed on: 02/22/2012 13:31:31 [Selected by: Turner, Margo on: 2/22/2012 4:15:46 PM]

Comments (Assessment and Plan)

1) chest / epigastric / back pain - nc ct abd done, telemetry, trend ce, ekg , consult Cardiology, anit emetics and analgesics
2) history of valve replacement surgery - inr 2.8, coumadin on hold as pt is npo - await Cardiology recommendations
3) n/v/d - nop, ivf, stool culture
Meds and plans as per orders. [Originally Entered by: Turner, Margo (MD) on: 2/22/2012 4:15:46 PM]
1) chest / epigastric / back pain - nc ct abd done, telemetry, trend ce, ekg , anti emetics and analgesics
2) history of valve replacement surgery - inr 2.8, coumadin on hold as pt is npo - await further recommendations
3) n/v/d - npo, ivf, stool culture & stool for c. diff
Meds and plans as per orders. [Changed to this value by: Turner, Margo (MD) on: 2/22/2012 8:20:12 PM]

Last Updated / Modified 02/22/2012 20:20:12
Turner, Margo (MD)

ABINGTON MEMORIAL HOSPITAL
EMERGENCY DEPARTMENT

Strimber, Abraham
DOB: 11/14/1950 M61
Wt/Ht:
MedRec: 0482935
AcctNum: 1205350964

Patient Data

Complaint: CHEST PAIN
Triage Time: Wed Feb 22, 2012 11:45
Urgency: ESI Level 2
Bed: ED ETC5
Initial Vital Signs: 2/22/2012 11:42
BP:169/84
P:66
O2 sat:

ED Attending: Fisher, MD, Steven
Primary RN: Stebulis, RN, Lynne

R:18
T:96.1 (PO)
Pain:

TRIAGE (Wed Feb 22, 2012 11:45 LS)
PATIENT: NAME: Strimber, Abraham, AGE: 61, GENDER: male, DOB: Tue Nov 14, 1950, TIME OF GREET: Wed Feb 22, 2012 11:40, MEDICAL RECORD NUMBER: 0482935, ACCOUNT NUMBER: 1205350964. (Wed Feb 22, 2012 11:45 LS)
ADMISSION: URGENCY: ESI Level 2, BED: UNASSIGN. (Wed Feb 22, 2012 11:45 LS)
VITAL SIGNS: BP 169/84, Pulse 66, Resp 18, Temp 96.1, (PO), Time 2/22/2012 11:42. (11:42 LS)
COMPLAINT: CHEST PAIN. (Wed Feb 22, 2012 11:45 LS)
ASSESSMENT: **pt here w/ c/o legs vibrating and abd feels like is going to explode. pt denies chest pain. pt states he had 1 episode of loose stools today after eating radishes, tomatoes, eggs and locs. pt also had centrum vitamin. pt w/ multiple complaints.** (Wed Feb 22, 2012 11:45 LS)
GCS: Total GCS score is 15: eye opening (4), verbal response (5), motor response (6). (Wed Feb 22, 2012 11:45 LS)
PROVIDERS: TRIAGE NURSE: Lori Ischinger, RN. (Wed Feb 22, 2012 11:45 LS)
PREVIOUS VISIT ALLERGIES: Iodinated contrast – Anaphylaxis, Iodinated radiocontrast dyes, Ivp dye. (Wed Feb 22, 2012 11:45 LS)

HPI (17:15 SF)
HPI TRANSCRIPTION: The patient is a 61–year–old gentleman with a history of aortic valve dysfunction status post remote St. Jude valve placement, hypertension who presents with the abrupt onset of the sensation that he had a lid of a paint can that began in his epigastrium and slammed up into his jaw and then came down and continues to compresses upon his abdomen. It came on abruptly after he loaded the car. The patient does not believe he overexerted myself. He felt mildly diaphoretic and noted that his legs began to shake. He denied dyspnea. He did not pass out. He denies a history of AAA. The patient denies a history of coronary artery disease. The patient has persistent pain in his epigastrium. The patient did have a scant amount of diarrhea but does not believe that this is related to GI distress.

Dictated by: Steven Fisher.

KNOWN ALLERGIES
Iodinated contrast – Anaphylaxis, Iodinated Radiocontrast Agents – Entered brand: iodinated contrast — anaphylaxis, Iodinated Radiocontrast Agents – Entered brand: iodinated radiocontrast dyes — undefined, Iodinated Radiocontrast Agents – Entered brand: ivp dye — undefined, Iodinated radiocontrast dyes, Ivp dye

CURRENT MEDICATIONS (11:45 LS)

Warfarin Sodium: mg ORAL Daily .
Multivitamin
**Complete per patient/outside source*
Metoprolol Tartrate: mg ORAL Every 12 hours .

PAST MEDICAL HISTORY (Wed Feb 22, 2012 11:45 LS)
MEDICAL HISTORY: Hypertension, **No past medical history, (No Documented Health Issues) No Documented Health Issues .**
SURGICAL HISTORY: **History of orthopedic, left, fibula x2 fx, History of valve replacement, mitral valve(st. Jude). aortic valve.**
PSYCHIATRIC HISTORY: **No history of anxiety, No history of bipolar, No history of depression.**
SOCIAL HISTORY: **Denies alcohol abuse, Denies tobacco abuse, Denies drug abuse.**
FAMILY HISTORY: **Family history includes hypertension.**

ROS (17:15 SF)
ROS TRANSCRIPTION: All systems were reviewed and negative except as stated in the patient's HPI.

Dictated by: Steven Fisher.

VITAL SIGNS
VITAL SIGNS: BP: 169/84, Pulse: 66, Resp: 18, Temp: 96.1 (PO), Time: 2/22/2012 11:42. (11:42 LS)
BP: 148/72, Pulse: 73, Resp: 18, O2 sat: 97 on RA, Time: 2/22/2012 12:37. (12:37 LSI)
BP: 131/59, Pulse: 70, Resp: 18, O2 sat: 94 on RA, Time: 2/22/2012 12:59. (12:59 LSI)
BP: 165/77, Pulse: 66, Resp: 17, O2 sat: 96 on RA, Time: 2/22/2012 15:26. (15:26 PB4)
BP: 160/70, Pulse: 80, Resp: 17, O2 sat: 96 on RA, Time: 2/22/2012 15:46. (15:46 PB4)

PHYSICAL EXAM (17:15 SF)
PHYSICAL EXAM TRANSCRIPTION: The patient is awake and alert. He does move all extremities spontaneous. He
a appears to be grossly neurologically intact, very kind and cooperative. Conjunctivae are not pale. Mucous membranes are moist. Neck: Supple. Lungs: Clear. Cardiac rate is regular. No murmurs or gallops but he does have a systolic click. Belly is very generously proportioned. It makes the examination difficult. The patient is tender in the epigastrium. I do feel an aortic pulsation which is concerning given this gentleman's proportions. He does not have any distension or tympany. No peritoneal signs. The patient's vascular examination in his lower extremities he is symmetrically diminished. His legs do appear to be warm and well–perfused. There is no mottling. He has preserved strength and sensation.

Dictated by: Steven Fisher.

DIFFERENTIAL DIAGNOSIS (17:15 SF)
DIFFERENTIAL DIAGNOSIS TRANSCRIPTION: 1. Epigastric pain of uncertain etiology. 2. Gastrointestinal distress.

3. Abdominal aortic aneurysm. 4. Renal colic. 5. Acute coronary syndrome. These and other diagnoses were considered.

Dictated by: Steven Fisher.

ORDERS

Comprehensive Metabolic Pnl by Fisher, MD, Steven for Fisher, MD, Steven on Wed Feb 22, 2012 12:24 Status: Done by System Wed Feb 22, 2012 13:13
PTT.. by Fisher, MD, Steven for Fisher, MD, Steven on Wed Feb 22, 2012 12:24 Status: Done by System Wed Feb 22, 2012 13:05
Infusor – Insert by Fisher, MD, Steven for Fisher, MD, Steven on Wed Feb 22, 2012 12:24 Status: Done by System Wed Feb 22, 2012 12:27
Protime.. by Fisher, MD, Steven for Fisher, MD, Steven on Wed Feb 22, 2012 12:24 Status: Done by System Wed Feb 22, 2012 13:02
CBC/Diff/Platelets by Fisher, MD, Steven for Fisher, MD, Steven on Wed Feb 22, 2012 12:24 Status: Done by System Wed Feb 22, 2012 13:08
EKG 12 Lead – Pain Abd by Fisher, MD, Steven for Fisher, MD, Steven on Wed Feb 22, 2012 12:24 Status: Done by System Wed Feb 22, 2012 12:27
Cardiac Troponin by Fisher, MD, Steven for Fisher, MD, Steven on Wed Feb 22, 2012 12:24 Status: Done by System Wed Feb 22, 2012 13:21
CK w/Reflexive MB by Fisher, MD, Steven for Fisher, MD, Steven on Wed Feb 22, 2012 12:24 Status: Done by System Wed Feb 22, 2012 13:13
CT Abd/Pelvis WITHOUT Contrast by Fisher, MD, Steven for Fisher, MD, Steven on Wed Feb 22, 2012 12:31 Status: Done by System Wed Feb 22, 2012 13:36
Urinalysis POC by Fisher, MD, Steven for Fisher, MD, Steven on Wed Feb 22, 2012 12:37 Status: Active
Physician Consult – OTHER by Majeski, AA, Jennifer for Fisher, MD, Steven on Wed Feb 22, 2012 13:59 Status: Done by System Wed Feb 22, 2012 14:00
Physician Consult – UNREFERRED by Majeski, AA, Jennifer for Fisher, MD, Steven on Wed Feb 22, 2012 14:08 Status: Done by System Wed Feb 22, 2012 14:08
Place Patient in Observation Status by Majeski, AA, Jennifer for Fisher, MD, Steven on Wed Feb 22, 2012 14:27 Status: Done by System Wed Feb 22, 2012 14:27
Nutrition–Doc to RN – Meds NSO by Turner, MD, Margo for Turner, MD, Margo on Wed Feb 22, 2012 15:56 Status: Active
Physician Group Consult Routine NSO by Turner, MD, Margo for Turner, MD, Margo on Wed Feb 22, 2012 15:57 Status: Active
O2 Therapy Cannula NSO by Turner, MD, Margo for Turner, MD, Margo on Wed Feb 22, 2012 16:01 Status: Active
Activity NSO by Turner, MD, Margo for Turner, MD, Margo on Wed Feb 22, 2012 16:01 Status: Active
Doc to Nurse by Turner, MD, Margo for Turner, MD, Margo on Wed Feb 22, 2012 16:01 Status: Active
Vital Signs NSO by Turner, MD, Margo for Turner, MD, Margo on Wed Feb 22, 2012 16:01 Status: Active
CK w/Reflexive MB NSO by Turner, MD, Margo for Turner, MD, Margo on Wed Feb 22, 2012 16:01 Status: Active
CK w/Reflexive MB NSO by Turner, MD, Margo for Turner, MD, Margo on Wed Feb 22, 2012 16:01 Status: Active

O2 Therapy Cannula NSO by Turner, MD, Margo for Turner, MD, Margo on Wed Feb 22, 2012 16:01 Status: Active
Notify H.O.–Signs/Symptoms NSO by Turner, MD, Margo for Turner, MD, Margo on Wed Feb 22, 2012 16:01 Status: Active
Diet – NPO by Turner, MD, Margo for Turner, MD, Margo on Wed Feb 22, 2012 16:01 Status: Active
O2 Therapy Cannula NSO by Turner, MD, Margo for Turner, MD, Margo on Wed Feb 22, 2012 16:01 Status: Active
Notify H.O.–Vital Signs NSO by Turner, MD, Margo for Turner, MD, Margo on Wed Feb 22, 2012 16:01 Status: Active
Diet – NPO by Turner, MD, Margo for Turner, MD, Margo on Wed Feb 22, 2012 16:01 Status: Cancelled by System Wed Feb 22, 2012 16:03
Telemetry Monitor NSO by Turner, MD, Margo for Turner, MD, Margo on Wed Feb 22, 2012 16:01 Status: Active
Cardiac Troponin NSO by Turner, MD, Margo for Turner, MD, Margo on Thu Feb 23, 2012 00:00 Status: Active
Cardiac Troponin NSO by Turner, MD, Margo for Turner, MD, Margo on Thu Feb 23, 2012 00:00 Status: Active
Comprehensive Metabolic Pnl NSO by Turner, MD, Margo for Turner, MD, Margo on Thu Feb 23, 2012 06:00 Status: Active
CBC/Diff/Platelets NSO by Turner, MD, Margo for Turner, MD, Margo on Thu Feb 23, 2012 06:00 Status: Active
Protime.. NSO by Turner, MD, Margo for Turner, MD, Margo on Thu Feb 23, 2012 06:00 Status: Active
EKG 12 Lead NSO by Turner, MD, Margo for Turner, MD, Margo on Thu Feb 23, 2012 07:00 Status: Active

MEDICATION ADMINISTRATION SUMMARY

Drug Name	Dose Ordered	Route	Status	Time
Zofran	8 mg	IntraVenous Push	Cancelled	14:53 2/22/2012
*Ondansetron Hydrochloride Novaplus	4 mg	IntraVenous Push	Held	16:04 2/22/2012
*Morphine Sulfate	2 mg	IntraVenous Push	Held	16:04 2/22/2012
*Sodium Chloride 0.9%, Intravenous	125 mL/hr	IntraVenous Continuous	Held	16:04 2/22/2012
*Morphine Sulfate	4 mg	IntraVenous Push	Given	15:38 2/22/2012
*Ondansetron Hydrochloride Novaplus	8 mg	IntraVenous Push	Held	15:26 2/22/2012
Morphine Sulfate	4 mg	IntraVenous Push	Given	13:40 2/22/2012

*Additional information available in notes, Detailed record available in Medication Service section.

MEDICATION SERVICE

Morphine Sulfate: Order: Morphine Sulfate : 4 Mg/Ml Solution – Dose: 4 mg : IntraVenous Push
Ordered by: Steven Fisher, MD
Entered by: Steven Fisher, MD Wed Feb 22, 2012 12:37
Documented as given by: Lynne Stebulis, RN Wed Feb 22, 2012 13:40
Patient, Medication, Dose, Route and Time verified prior to administration.
, Amount given: 4 mg, IV SITE #1 IVP, initial medication, Slowly, Catheter placement confirmed via flush prior to administration, IV site without signs or symptoms of infiltration during medication administration, No swelling during administration, No drainage during administration, IV flushed after administration, Correct patient, time, route, dose and medication confirmed prior to administration,

Patient advised of actions and side–effects prior to administration, Allergies confirmed and medications reviewed prior to administration.

Morphine Sulfate: Order: Morphine Sulfate : 4 Mg/Ml Solution – **Dose:** 4 mg :
IntraVenous Push
Notes: per verbal order
Ordered by: Steven Fisher, MD
Entered by: Perry Benedict, RN Wed Feb 22, 2012 15:31
Documented as given by: Perry Benedict, RN Wed Feb 22, 2012 15:38
Patient, Medication, Dose, Route and Time verified prior to administration.
, Amount given: 4mg, IV SITE #1 IVP, repeat same medication, Slowly, Connections checked prior to administration, Line traced prior to administration, Catheter placement confirmed via flush prior to administration, IV site without signs or symptoms of infiltration during medication administration, No swelling during administration, No drainage during administration, IV flushed after administration, Correct patient, time, route, dose and medication confirmed prior to administration, Patient advised of actions and side–effects prior to administration, Allergies confirmed and medications reviewed prior to administration, Emotional support needed and given.

Morphine Sulfate: Order: Morphine Sulfate : 2 Mg/Ml Solution – **Dose:** 2 mg :
IntraVenous Push
Schedule: Due: Feb 22, 2012 15:59
Notes: EVERY 4 HOURS; PRN: PAIN; MORPHINE INJECTABLE
Ordered by: Margo Turner, MD
Entered by: Margo Turner, MD Wed Feb 22, 2012 16:04 ,
Held by: Margo Turner, MD Wed Feb 22, 2012 16:04 Reason: EVERY 4 HOURS; PRN: PAIN; MORPHINE INJECTABLE.

Ondansetron Hydrochloride Novaplus: Order: Ondansetron Hydrochloride Novaplus (Ondansetron Hydrochloride) : 2 Mg/Ml Solution – **Dose:** 8 mg : IntraVenous Push
Schedule: Due: Feb 22, 2012 14:49
Notes: ONCE; ONDANSETRON INJECTABLE; ADMIN: Push over 1 minute.
Ordered by: Steven Fisher, MD
Entered by: Steven Fisher, MD Wed Feb 22, 2012 14:53 ,
Held by: Perry Benedict, RN Wed Feb 22, 2012 15:26 Reason: Patient refused.

Ondansetron Hydrochloride Novaplus: Order: Ondansetron Hydrochloride Novaplus (Ondansetron Hydrochloride) : 2 Mg/Ml Solution – **Dose:** 4 mg : IntraVenous Push
Schedule: Due: Feb 22, 2012 15:58
Notes: Q4H; PRN: NAUSEA/VOMITING; ONDANSETRON INJECTABLE; ADMIN: Push over 1 minute.
Ordered by: Margo Turner, MD
Entered by: Margo Turner, MD Wed Feb 22, 2012 16:04 ,
Held by: Margo Turner, MD Wed Feb 22, 2012 16:04 Reason: Q4H; PRN: NAUSEA/VOMITING; ONDANSETRON INJECTABLE; ADMIN: Push over 1 minute.

Sodium Chloride 0.9%, Intravenous: Order: Sodium Chloride 0.9%, Intravenous (Sodium Chloride) : Sodium Chloride 0.9% Solution – **Dose:** 125 mL/hr : IntraVenous Continuous
Schedule: Due: Feb 22, 2012 15:57
Notes: SODIUM CHLORIDE 0.9% INFUSION; VOLUME: 1000 MILLILITER(S)
Ordered by: Margo Turner, MD
Entered by: Margo Turner, MD Wed Feb 22, 2012 16:04 ,
Held by: Margo Turner, MD Wed Feb 22, 2012 16:04 Reason: SODIUM CHLORIDE 0.9% INFUSION; VOLUME: 1000 MILLILITER(S).

(CANCELLED) Zofran: Order: Zofran (Ondansetron Hydrochloride) : 2 Mg/Ml Solution –
Dose: 8 mg : IntraVenous Push
Ordered by: Steven Fisher, MD
Entered by: Steven Fisher, MD Wed Feb 22, 2012 14:42
Cancelled by: Steven Fisher, MD. Wed Feb 22, 2012 14:53
, Cancel reason: CLARIFICATION OF ORDER; ONCE; ONDANSETRON INJECTABLE; ADMIN: STAT(ETC).

RESULTS
RADIOLOGY: CT ABD PEL W O CONTRAST Wed Feb 22, 2012 13:35,

HISTORY: Mid upper abdominal and back pain.

TECHNIQUE: Helical axial images were obtained from the domes of the diaphragm through the pubic symphysis. Neither oral nor intravenous contrast was administered. Coronal and sagittal reformatted images were also evaluated.

Comparison: None.

FINDINGS:

The patient is status post median sternotomy. The heart is enlarged. There is no pericardial effusion. There is dependent atelectasis at the lung bases posteriorly.

Evaluation of the abdominal and pelvic organs is limited without intravenous contrast.

The liver is unremarkable without evidence of solid mass or biliary ductal dilatation. The gallbladder is unremarkable in appearance.

The spleen is normal in appearance. The pancreas is unremarkable. The right adrenal gland is unremarkable. There is a subcentimeter low–attenuation nodule in the left adrenal gland which likely represents an adenoma.

There are no abnormally enlarged mesenteric, retroperitoneal, pelvic, or inguinal lymph nodes.

There is a small fat containing left inguinal hernia. The prostate gland is unremarkable. The urinary bladder is normal in appearance without focal mass or wall thickening.

There is no bowel obstruction, bowel wall thickening, or free air. No free fluid is visualized. A normal appendix is visualized.

No hydronephrosis or renal calculus is seen. There is a cystic lesion

in the lower pole the left kidney, which is likely a simple cyst, however is incomplete characterized on this noncontrast examination. Repeat study with intravenous contrast and be helpful to better characterize the nature of this lesion.

There is minimal aortoiliac atherosclerosis. There is no aneurysmal dilatation or evidence of dissection or rupture on this noncontrast study.

There are mild scoliotic and degenerative changes of the spine. No destructive bony lesions are visualized.

Impression: Somewhat limited study without intravenous contrast.

Cystic lesion in the left kidney is likely a simple cyst , however it is incompletely characterized without intravenous contrast. Ultrasound of the kidneys or CT scan with intravenous contrast would be helpful to better determine the nature of this lesion.

No abdominal aortic aneurysm. No evidence of dissection on this noncontrast study.

Cardiomegaly.

Signed by: GOLDMAN, YEDIDA
Signed on: 02/22/2012 13:31:31

. (13:38 SF)

(13:27 SF)

Measurement	Result	Units	Range
CARDIAC TROPONIN I Wed Feb 22, 2012 12:42			
CARDIAC TROPONIN I	<0.10	ng/ml	
	WITHIN REFERENCE		
	INTERVAL		<0.10

(13:27 SF)

Measurement	Result	Units	Range
COMP METABOLIC PANEL Wed Feb 22, 2012 12:42			
GLUCOSE, RANDOM	141	MG/DL	70–110
BLOOD UREA NITROGEN	14	MG/DL	0–23
CREATININE	1.32	MG/DL	0.00–1.25
SODIUM	141	MEQ/L	135–145
POTASSIUM	3.7	MEQ/L	3.5–5.1
CHLORIDE	105	MEQ/L	98–110
CO2	23	MEQ/L	20–31
ANION GAP	17		9–18

ABINGTON MEMORIAL HOSPITAL
EMERGENCY DEPARTMENT

Strimber, Abraham
DOB: 11/14/1950 M61
Wt/Ht:
MedRec: 0482935
AcctNum: 1205350964

AST	26	U/L	5–34
ALT	18	U/L	0–55
ALK PHOSPHATASE	68	U/L	40–150
TOTAL BILIRUBIN	0.5	MG/DL	0.2–1.2
CALCIUM	8.9	MG/DL	8.5–10.7
ALBUMIN	4.3	GM/DL	3.4–4.8
TOTAL PROTEIN	6.6	GM/DL	5.8–7.6
CALC GFR–NON AFRICAN AMERICAN	55	mL/min/1.73m2	>60
GFR AFRICAN AMERICAN	>60	mL/min/1.73m2	>60
GFR COMMENT	The GFR estimate is		
	not adjusted for		
	extreme body surface		
	area. Nor has it		
	been		
	validated for		
	children less than		
	18 years, pregnant		
	women or ethnic		
	groups		
	other than		
	Caucasian and		
	African American.		

(13:27 SF)

Measurement	Result	Units	Range
CK Wed Feb 22, 2012 12:42			
CK	161	U/L	30–200

(13:27 SF)

Measurement	Result	Units	Range
AUTO BLD COUNT + DIFF Wed Feb 22, 2012 12:42			
WBC	12.1	K/UL	4.0–12.0
RBC	5.02	M/UL	4.60–6.20
HGB	15.0	G/DL	14.0–18.0
HCT	43.8	%	42–52
MCV	87.4	FL	80–94
MCH	29.9	PG	27.0–33.6
MCHC	34.2	%	32.0–36.0
RDW	12.7	%	11.5–15.0
PLT	192	K/UL	140–400
MPV	8.1	FL	7.4–10.4
NEUTROPHILS	80	%	
LYMPH	11	%	
MONO	8	%	
EOS	1	%	
BASO	0	%	
ABS NEUTROPHILS	9.7	K/UL	1.8–9.0
ABS LYMPH	1.3	K/UL	1.5–3.2
ABS MONO	1.0	K/UL	0.0–0.9
ABS EOS	0.1	K/UL	0.0–0.5
ABS BASO	0.0	K/UL	0.0–0.2
DIFF TYPE	AUTOMATED		

(13:27 SF)

Measurement	Result	Units	Range
PTT Wed Feb 22, 2012 12:42			
APTT	40	SEC	22–35
HEPARIN THERPTC RNG	66–97 SEC*		
FOOTNOTE	*EQUIVALENT TO		
	0.3–0.7 UNITS OF		
	HEPARIN PER ML BY		
	FACTOR Xa ASSAY		
	TECHNIQUE.		

(13:27 SF)

Measurement	Result	Units	Range
PROTIME Wed Feb 22, 2012 12:42			
INTNATL NORM RATIO	2.8		

DIAGNOSTICS AND INTERPRETATIONS (17:15 SF)

DIAGNOSTIC–INTERPRETATION TRANSCRIPTION: The patient was saturating 97% on room air which is evidence of adequate oxygenation and not hypoxia. On the monitor, the patient remained in a first–degree block. The patient's laboratory values were reviewed by me. Please see electronic medical record. The patient's creatinine 1.32, INR of 2.8. CT of the abdomen, pelvis showed no evidence of AAA nor dissection. The patient has a cystic lesion over the left kidney of uncertain etiology. He also had noted cardiomegaly.

Dictated by: Steven Fisher.

EKG INTERPRETATION (12:23 SF)

12 LEAD EKG INTERPRETATION: 12 lead EKG interpreted by ED Physician, At: 12:23 PM, Compared with previous EKG, No previous EKG available, EKG shows **First–degree AV block, normal axis, T–wave inversions in aVL without prior for comparison.**

NURSING ASSESSMENT: COMPREHENSIVE

CONSTITUTIONAL: History obtained from patient, Patient is cooperative, alert and oriented x 3, Patient's skin is warm and dry, **Patient appears in pain distress.** (12:08 LS1)

SKIN: Patient denies pain to skin, Skin warm and dry. (12:08 LS1)

NEURO: GCS eye opening is 4, verbal response is 5, motor respone is 6 Total GCS=15, Pupils PERRL, Motor strength to all extremities are strong and equal, Patient denies paresthesias, No facial droop noted, Patient denies headache, nausea, vomiting. Patient's speech is clear and understandable. (12:08 LS1)

BACK: Patient complains of pain to **middle back**, Pain described as **aching**, **On a scale 0–10 patient rates pain as 6**, Duration of pain: **this morning.** (15:27 PB4)

RESPIRATORY/CHEST: No complaint of pain, Breath sounds clear bilaterally, No acute respiratory distress, No intercostal retractions, No supraclavicular retractions, Equal chest expansion, No nasal flaring, No cough, Able to speak in full sentences. (12:08 LS1)

CARDIOVASCULAR: Patient denies chest pain, No extremity edema noted, Positive peripheral pulses bilaterally, **Heart sounds regular.** (12:08 LS1)

ABDOMEN: nontender, Positive bowel sounds in all 4 quadrants, Patient denies vomiting, diarrhea, constipation, flank tenderness. No pulsatile masses noted to abdomen, **Abdominal pain is diffuse, Pain radiates to back, Abdomen is distended.** (12:08 LS1)

Patient denies nausea, **Abdominal pain is diffuse, On a scale 0–10 patient rates pain as 4.** (15:27 PB4)

nontender, Positive bowel sounds in all 4 quadrants, Patient denies vomiting, diarrhea, constipation, flank tenderness. No pulsatile masses noted to abdomen, **Abdominal pain is diffuse, Pain radiates to back, Abdomen is distended.** (15:40 LS1)

GENITOURINARY MALE: No complaint of pain, No discharge, No urinary complaints. (12:08 LS1)

FALL RISK: Total fall risk score is: 0. (12:08 LS1)

NOTES: **pt states he was walking up the driveway after loading things in the car felt "a rising**

metallic feeling like someone put a paint can in my stomach and the lid was rising up into my throat". Wife states pt became pale and clammy. Denies syncope. Pt had 2 episodes of diarrhea and +nausea. C/o abd distention and pain radiating to back. (12:08 LS1)

NURSING ASSESSMENT: NURSES NOTE (13:49 PB4)
TIME ASSESSED: **inital contact with patient, patient presents lying on right side, on cardiac monitor, speech clear rr non labored. patient states pain relief with after morphine, patient describes pain as being ' all over here' (rubbing abdomen) spouse at bedside, call bell with in reach.**

AA COMMUNICATIONS
PROCEDURE: PHYSICIAN NOTIFICATION, **dr singer**, responded at: 2;00 pm. (14:00 JM2)
PHYSICIAN NOTIFICATION, **ao**, responded at: 2:00 pm, reason: admission. (14:09 JM2)

NURSING PROCEDURE: CARDIAC MONITOR (12:08 LS1)
TIME: Patient placed on cardiac monitor, non-invasive blood pressure monitor, continuous pulse Oximetry. After procedure, patient tolerating monitoring.

NURSING PROCEDURE: COMMUNICATIONS
PROCEDURE: Hand-off Communication given at 1600, Hand-off Communication given to amber 3H, Provided opportunity to answer questions. (16:07 LS1)
escort called, they state patient is next to be picked up. (16:59 PB4)

NURSING PROCEDURE: EKG CHART (12:09 LS1)
TIME: EKG was performed at triage, 12 lead EKG Performed-left chest, After procedure, EKG for interpretation given to Dr. fisher.

NURSING PROCEDURE: IV (12:07 LS1)
TIME: in 1 attempt, IV established 20 gauge catheter inserted, into left Forearm, Flushed with 10 mL normal saline, Labs drawn at time of placement, Specimen labeled in the presence of the patient and sent to lab, No drainage noted at site, No redness, No tenderness, clear occulusive dressing applied.

NURSING PROCEDURE: TRANSPORT TO TESTS (12:52 LS1)
TIME: Patient transported to, CT scan, Patient transported via, cart, Patient accompanied by, nurse.

MEDICAL DECISION MAKING (17:15 SF)
MEDICAL DECISION MAKING TRANSCRIPTION: Importantly, the patient received multiple doses of morphine intravenously.
Additionally received some IV fluids. The patient's pain did feel better.
Then, the patient had the advent of vomiting. The exact precipitant of the patient's pain remained unclear. I was worried based upon his examination that he could have a AAA. This did not appear to be the case. The patient did not receive IV contrast as he has a significant allergy to IV dye. Ultimately, the patient was admitted given our uncertainty as to the patient's pain. He was

clearly uncomfortable. The patient's case was discussed at length with the hospitalist who admitted the patient..

Dictated by: Steven Fisher.

ATTENDING NOTES (16:07 SF)
NOTES: I have reviewed the current medications and all elements of the patient's history obtained by nursing staff. I have personally seen and examined this patient. I have fully participated in the care of this patient., Physician dictation number: **246830.**

DIAGNOSIS (14:09 SF)
FINAL: PRIMARY: **Chest pain [NOS]**, ADDITIONAL: **Epigastric pain.**

DISPOSITION
PATIENT: Disposition: A – OBSERVATION, Placement , Condition: Guarded . (14:09 SF)
Disposition: . (14:29 JM2)
Disposition: . (14:29 JM2)
Disposition: . (15:44 LRM1)
Disposition: . (16:09 LS1)
Remove from ER. (17:09 PB4)
NOTES: hospitalist –green team– tele obs. (14:09 SF)

PRESCRIPTION
No recorded prescriptions

IMAGING (12:56 JM2)
EKG: Image captured from scanner.

ADMIN
DIGITAL SIGNATURE: Fisher, MD, Steven. (Thu Feb 23, 2012 10:25 SF)
CHART FAX: JULIAN JAKOBOVITS 4105800773. (17:09 PB4)
PATIENT DATA CHANGE: A08 9000878090803310 by Interface. (11:49)
Primary Nurse changed from (none) to Lynne Stebulis, RN. (11:49 LS1)
Extender: Phone 7643. (12:19 LS1)
Attending changed from (none) to Steven Fisher, MD. (12:23 SF)
A04 3426565 by Interface, Middle Name: (none), Payment: 309, Zip code: 21208, Language: Z, Race: W, Phone number: 410–272–1616, Family Dr: Julian Jakobovits, Triage Transport: AT . (12:35)
Ins Verification: Completed – BC/KS OBS Eligible. (12:55 ADIN)
A08 3428273 by Interface, Middle Name: (none), Family DR: Julian Jakobovits . (14:28)
A08 3428284 by Interface, Middle Name: (none), Family DR: Julian Jakobovits . (14:28)
A08 3428285 by Interface, Middle Name: (none), Family DR: Julian Jakobovits . (14:28)
A08 3428293 by Interface, Middle Name: (none), Admitting: Green Dept Of Med, Family DR: Julian Jakobovits . (14:29)
A08 3428295 by Interface, Middle Name: (none), Family DR: Julian Jakobovits . (14:29)
Extender: Phone 7646. (15:56 PB4)
BEDBOARD ENTRY: Request Date/Time: Feb 22, 2012 14:29, Diagnosis: Chest pain [NOS],

Diagnosis 2: Epigastric pain, Diagnosis 3: (none), IP Area Request: Observation – Telemetry, Admitting Doctor: Green Dept Of Med, Is this an AO admission?: N/A – not an AO admission. (14:29 JM2)

Request Date/Time: Feb 22, 2012 14:29, Diagnosis: Chest pain [NOS], Diagnosis 2: Epigastric pain, Diagnosis 3: (none), IP Area Request: Observation – Telemetry, Admitting Doctor: Green Dept Of Med, Is this an AO admission?: N/A – not an AO admission. (14:29 JM2)

Request Date/Time: Feb 22, 2012 14:29, IP Area Request: Observation – Telemetry, Admit Area: 3 Highland (X–2310), Admitting Bed: 3H02–1, Bed Ready : Yes. (15:44 LRMI)

Request Date/Time: Feb 22, 2012 14:29, Report Called: Yes, IP Nurse called for report?: Yes, Report given to?: amber, Opportunity to answer questions?: Yes, Reason for delay after report given: escort. (16:09 LS1)

Key:
ADIN=Dinkins, AA, Adraia JM2=Majeski, AA, Jennifer LRMI=Malone–Kirby, RN, Lisa LS=Ischinger, RN, Lori LS1=Stebulis, RN, Lynne MT3=Turner, MD, Margo PB4=Benedict, RN, Perry SF=Fisher, MD, Steven

Exhibit B

IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF PENNSYLVANIA

- - -

GARY B. FREEDMAN, : NO.
ESQUIRE, Administrator: 2:13-CV-3145-CDJ
of the ESTATE OF :
ABRAHAM STRIMBER, :
deceased, and :
BRACHA STRIMBER :
:
v. :
:
STEVEN FISHER, M.D., :
et al. :

- - -

February 24, 2014

- - -

Oral deposition of STEVEN FISHER, M.D., taken pursuant to notice, was held at Abington Memorial Hospital, 1200 Old York Road, Abington, Pennsylvania 19001, beginning at 9:14 a.m., on the above date, before Holli Goldman, a Court Reporter and Notary Public in and for the Commonwealth of Pennsylvania.

- - -

observation unit at 14:09, and I don't readily have what time he left the department.

Q. Okay. What is the observation unit?

A. Forgive me. That's something that's usually recorded, when the patient leaves the department. I'm not sure why it's not on this last page.

MR. CAMHI: He asked you what is the observation unit.

THE WITNESS: The observation unit is an area that is utilized to sequester patients that are admitted to observations so that they follow more of a routine so that their care can be coordinated and expedited.

BY MR. AUSSPRUNG:

Q. My question is little more simplistic than that, what I intended.

That's an inpatient area?

A. No. It's technically an outpatient area.

Q. Is it part of the emergency department?

A. It is not.

Q. So it's technically an outpatient area where patients are observed pending being placed on a inpatient floor somewhere?

A. It's an area where they receive further care until they may meet criteria, if you will, to be admitted to the hospital.

Q. But it is not an area that is manned or staffed by emergency department personnel?

A. Correct.

Q. Who mans or staffs that area?

A. A physician assistant under the direction of -- well, other primary care physicians as well as hospitalist teams.

Q. Okay. So your understanding is that the patient went to the -- and I recognize you weren't the attending

physician anymore once he went to the observation area, correct?

A. Correct.

Q. So once Mr. Strimber gets in the observation area, was it your understanding that Dr. Turner and the physician assistant in the area were providing care?

A. Correct.

Q. All right. What was Mr. Strimber chief complaint in the emergency department?

A. What he provided to me or --

Q. Yes.

A. Abdominal pain.

Q. Okay. Why on the very first page of patient data, where it says "Complaint" at the top, does it say, "Complaint: Chest pain"?

A. That would have been generated by the nurse who met him at the triage window, I believe.

Q. So that is a field that is filled in by that triage nurse?

A. I hesitate, because it may have been something that was generated by the nurse seated at the window, but then possibly repopulated by the primary nurse. I'm not sure.

Q. Okay. That can be -- you say repopulated, meaning that part of the form can be changed by the nurse?

A. No. I -- I'm not sure. I'm not sure exactly how that was generated that day.

Q. Okay. Well, on the very first line, it says, "chest pain"; and then if you go down under "Triage," about five lines down, there's a spot for complaint, and it again says, "chest pain," correct?

A. It does.

Q. And the second place where it says "chest pain," there's a date and time and a nurse's initials, correct?

A. It does.

Q. And who is LS?

A. Lynne Stebulis.

see if that aneurysm was actually in the thoracic cavity, correct?
A. Correct. His symptoms -- his complaint and symptoms focused upon his abdomen.
I'm not going to order a study just because I can. I have to try to focus my assessment.
Q. Well, you order studies to help you rule out life-threatening potential diagnoses, correct?
A. Correct.
Q. And an aortic dissection is a life-threatening diagnosis, correct?
A. Yes.
Q. And an aortic thoracic aneurysm is a life-threatening diagnosis, correct?
A. Yes.
Q. And you were concerned that there was an aortic aneurysm only in the abdomen, not in the thorax, correct?
A. Correct.
Q. And you didn't feel there

was any need to look for that aneurysm in the thorax, correct?
A. I focussed upon the abdomen because that's where the patient's both complaint and physical examination led me.
Q. Well, you didn't focus on the abdomen. You looked exclusively in the abdomen, correct?
MR. SHUSTED: Objection. Argumentative.
MR. CAMHI: Could you repeat the question, please?
THE COURT REPORTER: Question: Well, you didn't focus on the abdomen. You looked exclusively in the abdomen, correct?
MR. CAMHI: Go ahead, answer that.
THE WITNESS: That's where the focus of the assessment was. I mean, the CAT scan did encompass significant portions of the chest,

but I thought the patient had an abdominal complaint.
BY MR. AUSSPRUNG:
Q. Well, when patients have aortic dissections or aortic aneurysms in their thorax, where are they generally located? What's the most common location, do you know?
A. Well, it depends on who the patient is, but often times --
Q. A patient with a valve, where would that be located generally?
A. The ascending aorta.
Q. Okay. Which is the area above the heart, correct?
A. Correct.
Q. You didn't expect there'd be any imagining of the ascending aorta on an abdominal CAT scan, correct?
A. Again, the patient's history and physician examination led me to focus upon the abdomen.
Q. When you made the order -- you made the decision and you ordered the

abdominal CT scan, correct?
A. I did, yes.
Q. Okay. When you ordered that, did you anticipate that that abdominal CT scan would contain some imaging of the ascending aorta?
A. No. I was most concerned about the abdominal aorta based upon the patient's history and physical exam.
Q. Okay. So a little while ago when you told me that an abdominal CT scan contains significant imaging of the thorax, what did you mean by that?
MR. CAMHI: Object to the form of the question, but you can answer that.
He didn't say what you said, but he can explain. Go ahead.
THE WITNESS: The CAT scans that are dedicated to a certain area will often extend beyond those margins above and below.
BY MR. AUSSPRUNG:
Q. There's a slice or two into

the thorax to get the very top of the abdomen, right?
A. I think there's more than a slice or two.
Q. How far up did the study go?
A. I don't know that I can speak to the exact length of the extension above the abdomen.
Q. Did you ever look at the actual CT study in this case?
A. I have, yes.
Q. When did you do that?
A. I guess within the last two weeks, and I likely reviewed the studies in real time.
Q. Okay. When I asked you what documents and things you reviewed, you didn't tell me you reviewed the CAT scan.
MR. CAMHI: Hold on. Hold on. Hold on.
Do you have a question you want to ask, because you asked him about documents, and you specifically said papers.

So if you want to ask him about films as a new question, why don't you do that now.
BY MR. AUSSPRUNG:
Q. What films did you review in preparation for today?
A. I reviewed the CAT scan of Mr. Strimber's abdomen.
Q. Any other radiologic studies that you reviewed?
A. No.
Q. Did you review any radiology reports?
A. That which is encompassed in the chart, yes.
Q. Okay. How far superior did the abdominal CT scan go?
A. It encompassed portions of the heart, ascending aorta --
Q. All right.
A. -- lung basis --
Q. You just said ascending aorta.
MR. SHUSTED: Can you let

him finish?
I'm sorry.
MR. CAMHI: You did interrupt his answer.
He asked you a question, and you began to answer.
MR. AUSSPRUNG: All right. Let her ask the question again. Give him whatever time he needs.
MR. CAMHI: You wanted to know what areas did it encompass.
MR. AUSSPRUNG: He said the ascending aorta, which --
MR. CAMHI: I agree, he did say that. But he also didn't finish, and you interrupted him.
You want to ask your question again; what areas did it cover?
Just start from the beginning and tell him.
MR. AUSSPRUNG: Can you just ask the doctor the question again, please?

THE COURT REPORTER: Question: How far superior did the abdominal CT scan go?
THE WITNESS: It encompassed portions of the heart, ascending aorta, some of the thoracic aorta, the lung basis, the diaphragm, and then extended through the abdomen and pelvis.
BY MR. AUSSPRUNG:
Q. Okay. You just said that the CT scan showed areas of the ascending aorta, correct?
A. I did, in fact, say that, yes.
Q. And that is the area of the aorta superior to the heart, correct?
A. It is.
Q. Did it show any areas of dissection or aneurysm?
A. No.
Q. Do you believe that that CT scan of the abdomen was adequate to evaluate the thoracic aorta?

A. It was, again, a study dedicated to the abdomen. One important caveat, to demonstrate any dissection that may have -- at any location, may have required intravenous contrast, which he could not have.

Q. Okay. But my question was a different one.

Is it your understanding that the abdominal CT scan that you ordered was adequate to evaluate the thoracic aortic?

A. It would not have been. But again, my focus was on the abdomen, because that's where the patient's history and physical examination led me.

I didn't have any intention of having it be an adequate study, because the patient's symptoms were abdominal.

Q. And you weren't, in fact, ordering it to evaluate the thoracic aorta, correct?

A. That's correct.

Q. You ordered the CT scan, in part, to evaluate the abdominal aorta correct?

A. Correct.

Q. Was the CT scan that you ordered adequate to evaluate the abdominal aorta?

A. It would have been better with contract.

Q. Well, that wasn't my question, sir.

My question was, was it -- as an emergency department physician, in ordering that scan and upon getting the report back, was the CT adequate to evaluate the abdominal aorta?

MR. SHUSTED: Objection. Argumentative.

MR. AUSSPRUNG: Let me ask a different question. I'll rephrase it in a different way, hopefully.

BY MR. AUSSPRUNG:

Q. Back in February of 2012, when you got the results of the abdominal

CT scan, did you feel that that study was adequate to rule out an abdominal aortic aneurysm?

A. To rule out an abdominal aortic aneurysm, yes.

Q. Did you feel it was adequate to rule out a thoracic aortic aneurysm?

A. I wouldn't have had that thought on February 22, 2012, because it was not my attempt to rule out a thoracic aortic aneurysm.

Q. The same question as to a thoracic aortic dissection.

A. The study would have been inadequate to rule out a thoracic aortic dissection. Primarily -- not primarily, but in part, a dissection would be difficult to find without contrast.

Q. Okay. So on February 22, 2012, did you ever consider ordering any other type of study to evaluate the heart or the thoracic aorta?

A. I didn't. I focused upon his abdomen, because again, that's where

the patient's history and physical examination led me.

Q. One of the studies that you can use to look for thoracic aortic aneurysm or dissections is an echocardiogram, correct?

A. Correct.

Q. Did you have the ability to order an echocardiogram in the emergency department on February 22, 2012?

A. Of what variety?

Q. Well, if you had worried that there was something going on in a superior area of the aorta -- I don't know if in the emergency department you can do your own echo, if you have to do a cardiology consult, and that they decide whether or not an echo is warranted.

What would be the process that you'd have to go through if you thought that you needed some evaluation for the thoracic aortic aneurysm?

A. Well, again, this is speculative, given the fact that I wasn't

remember?
A. Not that I remember.
Q. I understand that.
Frequently, you do.
They call you and find out why the patient's being admitted and things like that, correct?
A. Sure.
MR. CAMHI: You keep saying admitted, but it doesn't apply to this case.
MR. AUSSPRUNG: Oh.
MR. CAMHI: I think he told you earlier that it's actually an outpatient service.
I don't know that it matters that much, but I think the term "admitted to the observation unit" doesn't exist. "Sent to the observation unit" does exist.
BY MR. AUSSPRUNG:
Q. Doctor, I'm just not familiar with this whole observation unit thing. In the hospitals that I'm

familiar with, patients either got admitted or they went home.
And this seems to be some kind of intermediate thing to that; is that correct?
A. It is.
Q. So it's an area where the emergency department care has stopped, and some other attending physician makes a determination or monitors the patient for some period of time, correct?
A. Correct.
Q. Are you only allowed to be in the observation area for some specific period of time; like, you can't be there more than 12 hours or 24 hours or something like that?
A. No. It's intended to be, you know, up to 24 hours, but that often and unfortunately is not the case.
Q. Depends on bed status in the hospital and those kinds of things?
A. Well, observation primarily is a billing entity imposed on us by

Medicare, rather than a true patient care entity.
Q. Okay. I still don't understand what this unit is for.
Why would a patient go to the observation area as opposed to being admitted?
A. Because he, upon an InterQual review, did not meet criteria based upon the objective data found to be admitted as an inpatient.
Q. What is InterQual?
A. InterQual is a McKesson product that lays out guidelines that are followed by governmental and nongovernmental pairs -- not all of them, but most of them -- to determine whether or not a patient meets the severity of illness and intensity of service to be admitted to the hospital.
Q. Would it be fair to say that at the end of your emergency department evaluation, you were not comfortable discharging Mr. Strimber to home?

A. That is correct.
Q. Okay. And at the same time, he didn't meet that InterQual criteria for an admission?
A. That is correct.
Q. So the solution to that conundrum is the patient goes to an observation area for some intermediate period of time where another physician can evaluate and reassess?
A. That is correct.
Q. And the physician that was assigned to do that was Dr. Turner?
A. Yes.
Q. And that assignment to Dr. Turner as the physician was made by the hospital?
A. Well, it was -- I don't know that it's a dictum that comes from the hospital, but when the patient did not have a primary physician to admit to, that was, in fact, assigned to the hospitalist service, and Dr. Turner was that attending physician that particular

migration --
A. I believe that's an actual time.
Q. Okay. So around 14:09, you entered into the computer the patient's final primary diagnosis, correct?
THE WITNESS: Please forgive me.
MR. CAMHI: Do you need to get it?
We can go off if you do.
THE WITNESS: No. I don't need to get it.
- - -
(Whereupon, a discussion was held off the record.)
- - -
MR. AUSSPRUNG: I'm going to ask a fresh question.
MR. CAMHI: New question. Here we go.
BY MR. AUSSPRUNG:
Q. Am I correct that at approximately 14:09, you entered into the

medical record your final primary diagnosis for the patient in the emergency department?
A. Well, I don't consider chest pain or epigastric pain to be a diagnosis.
Q. Who entered the words "chest pain" there under final primary diagnosis?
A. I did.
Q. Okay. Why did you enter chest pain?
A. Well, I think my primary concern at that point was making sure that there was an indication for the patient to get further telemetry.
Q. I thought you told me the patient never complained to you of chest pain.
A. He did not.
Q. But you were aware that the patient had complained to the nurse of chest pain, correct?
A. Well, the primary nurse

taking care of the patient said that the patient denies chest pain.
Q. But it's written "chest pain" in multiple spots on the triage and nursing assessment, right?
A. The lack of chest pain is documented on several more important spots on the chart.
Q. So both chest pain and a lack of chest pain are documented in the medical record, correct?
A. Right. I -- correct.
Q. Why?
A. I can't speculate as to, you know, what someone else heard or was thinking at the triage window.
Q. Was this patient's evaluation partly based upon Abington Memorial Hospital's chest pain protocol?
A. The patient didn't have chest pain.
Q. But the patient got a reflexive EKG, correct?
A. So you're surmising that

EKGs are limited solely to people that have chest pain.
Q. Do you all patients with abdominal pain in Abington Memorial emergency department get an EKG?
A. Any patient that's 61 that has abdominal pain and is sweaty will get an EKG.
Q. Is that a standing order that the nurses can do without a physician intervention?
A. Well, it obviously is, because it happened. It was the first thing that happened.
Q. Well, I know it happened, but that doesn't mean there was an order for it.
A. Right. But the EKG occurred prior to my interactions with the patient.
Q. Does Abington Memorial Hospital emergency department have standing orders that nurses can follow without getting a physician's approval?

A. Well, no. It was, "These and other diagnoses were considered."
Q. Right. It was, 1, epigastric pain of uncertain etiology; 2, gastrointestinal distress; 3, abdominal aortic aneurysm; 4, renal colic; 5, acute coronary syndrome; and then you say other diagnoses were also considered, correct?
A. Yes.
Q. Okay. So of the five that you specified, which ones were life threatening?
A. Well, I mean, it's -- the epigastric pain of uncertain etiology could be. Triple-A is. And acute coronary syndrome could be.
Q. You did not have either dissection or thoracic aortic aneurysm on your differential diagnosis list, correct?
A. That is correct.
Q. Were these two other diagnoses considered at the time?
A. Had they been considered, I

would have pursued them.
Q. How would you have pursued them?
A. That's a complicated answer.
Q. Well, is there a specific testing you would have ordered?
A. Well, again, I hesitate to answer hypothetical questions, because my history and physical exam were inconsistent with those that you place on my differential.
Q. Well, your final diagnoses for the patient is listed as chest pain, sir, is it not?
MR. CAMHI: Didn't we cover that area before?
MR. AUSSPRUNG: Right.
MR. CAMHI: And he told you that he didn't have a diagnosis, and we went through this whole long questioning about --
BY MR. AUSSPRUNG:
Q. Well, can you explain to me why you wrote "chest pain" as the final

primary diagnosis if the patient didn't have that?
A. Because I think acute coronary syndrome was still part of that ongoing differential. I couldn't prove it at that point. There weren't, you know, obvious EKG changes. I didn't have a prior for comparison. The patient didn't have elevated cardiac markers, but needed repetitive enzymes. And so it would have been inappropriate to give the final diagnosis of acute coronary syndrome, but the diagnosis of chest pain would have allowed me to capture the capacity to have the patient on further telemetry.
Q. Would abdominal pain not have allowed you to do that?
A. It would be less clear.
Q. So you filled in the diagnosis of chest pain to allow the patient to continue to get telemetry?
A. Well, again, I hesitate to call that a diagnosis, but again, I

couldn't put something like acute coronary syndrome, because we didn't have any objective proof at that point.
Q. Could you put down EKG abnormality?
A. Well, again, I didn't know whether the patient's solitary T-wave inversion was historical or not. So I think it's possible I could have.
Q. Well, you could have put down something he had as opposed to something he didn't have, correct?
A. I could have.
Q. Was "chest pain," when you wrote final -- well, was "chest pain" selected from a drop-down menu or was that something you typed or dictated into the system?
A. I think I probably would have typed it.
Q. Okay. So you could have typed anything into that spot, correct?
A. I could have.
Q. Let's talk about the CT scan

Q. And you're very concerned that they get the best treatment they can?
MR. AUSSPRUNG: Objection. Relevance.
THE WITNESS: Unequivocally.
BY MR. SHUSTED:
Q. Okay. And you're not really concerned about billing entries whatever; you just want to make sure that they get the best treatment and you don't throw somebody out on the street; is that right?
A. That's, I think, established by our patients' customary evaluations of our service.
Q. And as a matter of fact, you're now the chairman of the department of emergency medicine; is that right?
A. That is correct.
Q. So for this particular patient, Mr. Strimber, you wanted to have him have further workup on a telemetry unit; is that fair?

A. Yes.
Q. And the reason why you would do it on a telemetry unit, so there could be continuous type of monitoring of his vital signs; is that correct?
A. We needed more information regarding the patient.
Q. And is that the reason why "chest pain" as the final diagnosis appears on the chart where you wrote it in there?
A. I think that's reasonable to conclude.
Q. Okay. So let's go back in time to when Mr. Strimber first presented to the emergency department, because I have entries here, some of which deny chest pain, some which say there's chest pain there, and I just want to make sure that we have an understanding as to what that means.
So I'm looking at page 1 of 12, and Dr. Aussprung questioned you about that and noted that the complaint

states chest pain in two different locations.
Do you see that by the nursing staff?
A. I do.
Q. All right. Underneath that second place where it says "Complaint: Chest pain," is there an assessment in there?
A. There is.
Q. All right. Now, is there an assessment of chest pain in there?
A. There is, that the patient specifically denies it.
Q. Is that a quote where it says "Patient denies chest pain"?
MR. CAMHI: You mean, does it exactly say "Patient denies chest pain"?
BY MR. SHUSTED:
Q. Are the words, quote, Patient denies chest pain, close quote, in the chart?
A. They are, under the nursing

assessment.
Q. Okay. How did that affect your assessment of the patient?
A. Well, it's part of the overall assessment. However, I place the majority of my practice based upon, you know, what I directly hear from the patient and what I glean from them by their history and physical examination.
Q. Okay. And on page 1 of 12, your history of present illness is in there; is that right?
A. Yes.
Q. Did you record a history of chest pain?
A. I did not.
Q. Would you have asked the patient if he had chest pain?
A. Yes.
Q. And if that patient had told you he had chest pain, would that have been in your HPI?
A. Yes.
Q. And on page 2 of 12, there's

Exhibit C

UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF PENNSYLVANIA

- - -

GARY B. FREEDMAN, ESQUIRE :
Administrator of the ESTATE:
OF ABRAHAM STRIMBER, :
Deceased and BRACHA :
STRIMBER :
:
v. :
:
STEVEN FISHER, M.D., et al.:NO. 13-03145

- - -

FEBRUARY 17, 2014

- - -

Oral deposition of BRACHA STRIMBER, taken pursuant to notice, was held at the LAW OFFICE OF LEON AUSSPRUNG M.D., LLC, One Commerce Square, 2005 Market Street, Suite 2300, Philadelphia, Pennsylvania, commencing at 2:30 p.m., on the above date, before LISA MARIE CAPALDO, RPR, a Registered Professional Reporter and Notary Public in and for the Commonwealth of Pennsylvania.

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deps@golkow.com

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twice. I don't know the timespan.
Q. How did he do it the first time?
A. I don't know which came first or second, whether it was the baseball one or the other one where he slipped on the grass and he broke it.
He slipped on the grass in front of our house, and I don't remember which was first and which was second. I just know it was the same leg. I'm guessing.
Q. Do you believe for both of those broken bone events he went to Abington's ER?
A. I'm not certain. I believe so, but I'm not certain.
Q. Did you go with him to those ER visits?
A. Of course, yes.
Q. How many other ER visits did he have before February of 2012 at Abington?
A. I don't know.

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Q. Do you know if there were any?
A. I don't know.
Q. What did he say, if anything, in the car on the way over to the hospital?
A. He was strangely silent.
Q. Were his eyes open or closed?
A. Open.
Q. Was he talking at all?
A. No.
Q. Any moaning or groaning?
A. No, he was silent, strangely silent.
Q. Had you considered calling an ambulance before you put him in the car?
A. No, an ambulance would take you to the closest hospital.
Q. Did you drive directly to the emergency department at Abington?
A. Yes.
Q. What happened when you got

Page 48

there?
A. We got out of the car and walked in together. Instead of waiting in line to be checked in, he pushed right through the doors and went to the back himself, which he never would have done. That frightened me. I knew something was very wrong.
Q. When you walk in through those doors, there's a desk where people sit behind and ask questions.
A. That's where I went, but he walked through the doors.
Q. When you first walked in, are you saying you went to that desk with the glass wall and spoke to the lady sitting behind the desk and he walked in through the doors?
A. I don't remember if I spoke to anyone. I remember him walking through the doors.
Q. What time did you get there?
A. I don't know.
Q. Did you also walk through

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those doors at some point?
A. At some point I did, when I was asked to walk through.
Q. Do you remember any of the names of the nurses that cared for him that day?
A. No.
Q. Do you remember the names of any of the doctors that saw him in the emergency department?
A. Yes.
Q. What name do you remember?
A. I remember a Dr. Fisher and I remember an admitting doctor, a Dr. Turner.
Q. Had you ever met Dr. Fisher before?
A. Not to my knowledge.
Q. Do you know if your husband ever met Dr. Fisher before?
A. I don't know.
Q. Are you able to estimate how long it was after you arrived at the emergency room that Dr. Fisher first saw

Page 50

your husband?
A. No.
Q. Was it more or less than an hour?
A. I don't know.
Q. Were you present when the nurse asked your husband what was bothering him?
A. Yes.
Q. What was his answer?
A. He was very nauseous. He had terrible back pain. He kept talking about this metallic taste rising to his mouth, shoulder and neck pain. His arm was bothering him. He kept vomiting, all the time.
Q. In the emergency room?
A. Projectile vomiting.
Q. Which arm was bothering him?
A. I don't know. He had so much back pain, there was no position where he could get comfortable.
Q. Do you know if the back pain was high, mid or low back?

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A. I don't know.
Q. I asked you, what did he tell the nurse when she asked him what was bothering him and you told me that, right?
A. Right.
Q. At some point, were you present when Dr. Fisher asked the same question, what's going on?
A. I was present, but I don't remember Dr. Fisher asking too many questions. All of the talking was done and all of the decision-making seemed to be done by Dr. Turner. And Dr. Fisher mostly stood on the side.
Q. Was there ever a moment that your husband was in the emergency department, before he got admitted upstairs, was there ever a moment where you were not with him?
A. Yes.
Q. When?
A. There were a few moments when I went out into the hallway to call

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his friends.
Q. How many separate times was that?
A. I don't know the count.
Q. Any other times other than to call friends?
A. I went to the bathroom, nothing prolonged.
Q. Do you know if he was taken to any place for any kind of testing and then returned back to the emergency department?
A. The CAT scan of his abdomen.
Q. How did you learn that he was going to have a CAT scan of the abdomen?
A. I don't remember which physician, but one of them told me they were going to do that.
Q. Did whoever that physician was tell you why they were going to do a CAT scan of the abdomen?
A. Because of his abdominal pain.

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Q. Do you remember a physician touching your husband's abdomen and him complaining about pain from that touching?
A. I'm not certain.
Q. What is your knowledge of your husband being allergic to intervenous dye or contrast?
A. I do know he was allergic to that.
Q. How do you know that?
A. I believe it was when he was at Temple Hospital and he had a procedure done that they discovered that.
Q. Do you remember what his reaction to that was?
A. No. I wasn't present in the room.
Q. Did you or your husband bring that allergy to someone's attention?
A. Absolutely, every time we went.
Q. Was there a discussion about

Exhibit D

IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF PENNSYLVANIA

- - -

GARY B. FREEDMAN, ESQUIRE, Administrator of the ESTATE OF ABRAHAM STRIMBER, deceased and BRACHA STRIMBER,	:	NO. 2:13-cv-3145-CDJ
Plaintiffs,	:	
v.	:	
STEVEN FISHER, M.D., et al.,	:	
Defendants.	:	

- - -

Thursday, September 25, 2014

- - -

Videotape deposition of MICHAEL E. CHANSKY, M.D., taken pursuant to notice, was held at the law offices of Christie Pabarue and Young, 1880 JFK Boulevard, 10th Floor, Philadelphia, Pennsylvania, commencing at 2:00 p.m., on the above date, before Amy M. Murphy, a Professional Court Reporter and Notary Public there being present.

- - -

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not done with your answer, just say so. It's not my intent to interrupt you and cut you off, so I'm going to try not to.

Was the EKG that was performed on Mr. Strimber part of his medical screening examination?

A. Yes.

Q. You don't say that in your expert report, sir.

MR. YOUNG: You mean using those explicit words?

BY MR. AUSSPRUNG:

Q. Well, I think you say it to the contrary, don't you? In your supplemental report, which has been marked already, it's the one-page report, you say, there is no medical screening evaluation for patients with chest pain beyond a thorough history and examination by the emergency room physician.

That's your statement, correct?

A. That's the initial step of the medical screening exam, yes.

Q. Well, you say there is no screening evaluations beyond the thorough history and examination. You don't say after history and examination you do an EKG, do you?

A. No. The -- well, yes. The purpose of the history and physical, based on the patient's chief complaint, is for the emergency medicine provider to decide if additional evaluation needs to be done to rule out an emergency medical condition. This policy that -- Exhibit-9, that purpose is that any patient with signs and symptoms that could be suggestive of ischemic disease have a EKG that's looked at by the emergency physician. And the EKG was done and looked at by Dr. Fisher and certainly played a role in his screening evaluation.

Q. So you believe that this policy on myocardial infarction applied up until the completion and interpretation of the EKG?

A. Yes.

Q. Okay. Well, right in the first line of the purpose of this policy it says, to provide guidelines for the identification, evaluation, and management of patients who present with chest discomfort or symptoms suggestive of ischemic coronary artery disease. Is that how Mr. Strimber presented?

A. Mr. Strimber had epigastric pain, which is a other symptom suggestive of cardiac ischemia. So it was a reasonable step to do an EKG and have it screened by Dr. Fisher.

Q. And do you -- I take it you disagree that patients who present with symptoms suggestive of ischemic coronary artery disease also required a chest x-ray?

MR. CAMHI: Can I hear the question again?

BY MR. AUSSPRUNG:

Q. Doctor, I take it that you do not believe that patients presenting

to the emergency department with symptoms suggestive of ischemic coronary artery disease require a chest x-ray or other thoracic imaging?

A. Not all of them, no. It depends on the history, physical, past history, medications, EKG, all the data that you acquire in doing your evaluation.

- - -

(Whereupon, Exhibit-10 was marked for identification.)

- - -

BY MR. AUSSPRUNG:

Q. Okay, Doctor. I'm going to mark as Exhibit-10 another policy of Abington Memorial Hospital that you didn't specifically mention. This is Exhibit-10. This is the policy on triage classification symptoms.

Did you review this policy in preparation of your expert opinions in this case?

A. Not specifically, but I'm

no. The information of -- new information and -- obviously, this is a strong hypothetical, because the triage nurse, Dr. Fisher, Dr. Turner, Mrs. Strimber, Mr. Strimber never complained of chest pain. So it's a complete hypothetical.

Had Mr. Strimber complained of chest pain, hypothetically, to the providers, then a further history pertinent to the chest pain would have been elucidated, what were you doing when it came on, what's it associated with, does it radiate, what makes it better, what makes it worse.

And then based on those questions, a chest x-ray may be part of the medical screening exam and it may not, but it is certainly not required.

BY MR. AUSSPRUNG:

Q. And one of the reasons that

you gave me to say that a chest x-ray is not required as part of the medical screening exam was that Abington Memorial Hospital has no policy or protocol applicable to patients presenting with Mr. Strimber's symptoms?

MR. YOUNG: Objection to the form. I don't think that's what he said.

BY MR. AUSSPRUNG:

Q. Let me ask it a different way. Let me cure the objection.

Do we agree that Abington Memorial Hospital had no written policy or procedure concerning the medical screening examinations for patients presenting with chest pain?

A. Yes.

Q. Do we agree, same question, for patients presenting with abdominal pain?

A. I've not looked through all of their policies and procedures. I don't know if they have a policy

regarding abdominal pain, but I know there was none for chest pain.

Q. You haven't seen a policy for abdominal pain, correct?

A. I have not.

Q. Under EMTALA, when a hospital does not have a written policy or procedure concerning a medical screening exam for a particular category of patients, how is it determined if an appropriate medical screening examination occurred?

A. It is determined that if a qualified provider evaluates the patient, which, as we said before in this case, was met by an emergency physician, and performs a history and physical with the intent to stabilize the patient and rule out an emergency medical condition.

Q. So, Doctor, do you -- are you of the opinion that Mr. Strimber does not have to receive a uniform medical screening exam based upon other patients who presented to the emergency department

at Abington Memorial Hospital with similar symptoms?

MR. YOUNG: Could you say that again? I just missed it.

- - -

(Whereupon, the pertinent portion of the record was read.)

- - -

MR. YOUNG: Objection to the form of the question. I just don't think it's clear as you've posed it. But you can respond to it, if you understand.

THE WITNESS: I am of the opinion -- I am of the opinion that -- let me make sure I'm answering this question right.

I'm of the opinion that Mr. Strimber's medical screening evaluation is tailored to him in that you can look at 200 or 300 other patients, and every one of those other patients has an independent history and physical

that determines the medical screening exam, because every patient, as I state on page 11 of my report, has different symptoms associated with their chief complaint, different past histories, different review of symptoms, they're on different medications, they have different allergies, they have different surgical histories, they have different social histories, and they have different physical exams.

So every individual, based on their history and physical, will -- requires a unique consideration for their medical screening and what further testing may be required for an emergency medical condition.

BY MR. AUSSPRUNG:

Q. So is it your opinion and testimony that every patient presenting

to the emergency department gets a unique medical screening evaluation -- examination?

A. Yes.

Q. So you disagree that EMTALA requires hospital to provide uniform screening to all patients who present with substantially similar complaints?

A. No. I don't disagree with that, because uniform screening, by my definition, is a history and physical by a competent clinical provider like an emergency physician. And an emergency physician, there are patients with abdominal pain that may decide they need Maalox and can go home, and there's abdominal pain that may require immediate CAT scan of the abdomen with contrast, and both had similar complaints and age. But, you know, one emergency physician, their medical screening evaluation reached a conclusion that Maalox was fine, and another emergency physician reached the conclusion that an imaging

test needed to be done to rule out.

So you have the same screening, which is a history and physical by a good provider, but perhaps different workups and approaches based on their independent evaluations.

Q. I think we established earlier that every patient that comes to the emergency department gets a history and physical examination, correct?

A. Yes.

Q. That is the medical screening examination for every patient?

A. Yes.

Q. And that is a uniform screening for every patient no matter what their complaint is, correct?

A. Yes. But the patient who twists his ankle versus the patient who has the worst headache of their life is going to have a very different initial history and physical with very different priorities. So when -- it's impossible to say similar-situated patients and

medical screen them exactly the same, because no two patients in the emergency department are alike.

Q. Well, doesn't that statement that you just made contradict the very foundation of EMTALA, which is that substantially similar patients must be -- receive a substantially similar medical screening examination which includes ancillary testing?

MR. YOUNG: I'm going to object to the form of the question. I think what you've just done is argued with the doctor as opposed to asking him a question. And I also think you've inserted into the question your interpretation of what the screening examination must be. I think he's already told you what he thinks about that.

MR. AUSSPRUNG: Actually, it was Judge Ditter's interpretation. It's from his order. So it's not

Exhibit E

Abington Memorial Hospital	Department Manual: EMERGENCY TRAUMA CENTER	Policy Number: ETC
Title: Myocardial Infarction – Primary Percutaneous Coronary Intervention for Acute ST Segment Elevation/New Left Bundle Branch Block Myocardial Infarction	**Category:** Patient Care	**Original Date:** 2/98
Policy Owner: ETC Director	**Keywords: MI and PCI**	**Last Review Date:** 5/07
Referenced With: [Type Here]	**Review Cycle:** Annual	**Last Revision Date:** 5/09

I. **PURPOSE:** To provide guidelines for the identification, evaluation, and management of patients who present with chest discomfort or symptoms suggestive of ischemic coronary artery disease (CAD) and are found to have acute ST segment elevation or new left bundle branch block (LBBB) consistent with acute myocardial infarction (AMI).

II. **PROCEDURE:**

A. All patients presenting to the Emergency Trauma Center with chest pain or other symptoms suggestive of acute cardiac ischemia will undergo a prompt evaluation. This evaluation will include the following:

1. A twelve lead electrocardiogram (ECG) will be performed as soon as possible after arrival

2. The nurse or clinical associate who performs the test will present the ECG directly to the responsible emergency physician for interpretation

3. If the emergency physician interprets the ECG as demonstrating an acute ST elevation/new LBBB myocardial infarction, he/she will notify the Interventional Cardiologist (IC) immediately

4. The ETC physician will perform a targeted history and physical to determine:
   - if an AMI is likely
   - if the patient has any contra-indications to PCI
   - whether the patient has a current cardiologist

5. After this evaluation, the ETC physician will then activate a Percutaneous Coronary Intervention (PCI) Alert and notify the patient's primary nurse immediately

6. If the ETC physician is uncertain if the patient is a candidate for PCI, he/she will discuss the management with the IC prior to activating a PCI Alert

B. Activation of PCI Alert

1. The ETC physician will notify the primary ETC nurse and the ETC Administrative Associate (AA)

2. The ETC AA will contact the IC as follows:
   - Abington Medical Specialists – Cardiology (AMS Cardiology)
     - 8:00 am – 5:00 pm (M - F except holidays) contact the office at x4075

- All other times and when there is no response at x4075, call the IC on call by contacting the AMS Cardiology answering service.
- Pennsylvania Heart and Vascular (PHV)
  - 8:00 am – 5:00 pm (M - F except holidays) and weekday nights, page Dr. Frechie. If no rapid response, AMS Cardiology should be contacted as above.

3. The ETC AA will activate a PCI Alert.
   - During normal catheterization laboratory working hours (M – F except holidays, 7:00 am – 5:00 pm) the AA will call 2437 to activate a PCI Alert
   - All other times, the AA will contact the hospital operator at 777 to activate a PCI Alert

4. The hospital operator will contact the members of the PCI Alert team after hours
   - Calls will be placed to:
     - Catheterization laboratory on-call team
     - CCU nurse manager (x2140)
     - Hospital Nursing Coordinator (x7103)
     - Bed Coordinator (x7980)
   - If no response by the catheterization team, the operator will contact the catheterization laboratory to determine if the team is already present

C. Roles/Responsibilities

1. Interventional Cardiologist
   - Will immediately respond to ETC to discuss patient with ETC physician
   - During off hours, if the IC is aware that the catheterization team is in the hospital, he should inform the catheterization laboratory to prepare
   - Facilitate rapid movement of the patient to the catheterization laboratory

2. ETC Physician
   - Interpret all ECG's as soon as possible after patient arrival
   - Perform rapid assessment to determine if Primary PCI is indicated
   - Initiate PCI Alert as above
   - Initiate medical management/stabilization of patient
   - Document interventions in the clinical record

3. ETC Primary Nurse
   - Ensure that ECG is performed and presented to the ETC physician as soon as possible after patient arrival
   - Activate PCI Alert packet
     - PCI Alert Tool
     - Consent Form
     - R2 pads
   - Initiate medical management/stabilization in a timely manner. This may include:
     - Administration of aspirin
     - Administration of beta-blocker
     - Administration of heparin
   - Prepare the patient for transfer to the catheterization laboratory with assistance from a secondary ETC nurse and/or CCU nurse:
     - Apply R2 pads if available
     - Bifurcate intravenous lines

  - Prepare inguinal area for procedure with use of clippers
  - Place patient on transport monitor
- Document times of each communication point on the PCI Alert Tool which will be used for performance assessment purposes only and not part of the permanent record
- Complete documentation of all interventions on the clinical record
- Assist catheterization team in the laboratory with patient preparation and treatment

4. CCU Nurse
   - Respond immediately to PCI Alert with appropriate equipment
   - Assist ETC nurse in stabilization and transport of patient to the catheterization laboratory
   - Assist catheterization team in the laboratory with patient preparation and treatment

5. Catheterization Laboratory Team
   - Immediately prepare room during weekday working hours
   - Repond to PCI Alert immediately and report to catheterization laboratory as soon as possible during on-call hours
   - Contact ETC Primary nurse when first catheterization team member arrives to facilitate patient movement to the laboratory

6. Nursing Coordinator
   - Respond to PCI Alert immediately
   - Open catheterization laboratory and prepare room for incoming cathetherization team members during on-call hours
   - Assist catheterization team, ETC nurse, and CCU nurse in the care of the patient until the full catheterization team arrives

7. Hospital Operator
   - Immediately call PCI Alert as above
   - Contact the ETC AA to inform them that the catheterization laboratory on-call team, nursing coordinator, and CCU have been notified

8. ETC AA
   - Assist ETC physician with the initiation of the PCI Alert and contacting the IC
   - Inform ETC physician and primary nurse that the team has responded
   - Direct the IC to the ETC physician
   - Document times of all calls/pages and response times in ED Pulsecheck and communicate this information to the primary nurse for documentation on the PCI Alert Tool
   - Confirm bed assignment with the bed coordinator/nursing supervisor
   - Contact appropriate resident

9. Bed Coordinator
   - Assign an intensive care unit bed for the patient as soon as possible
   - Communicate this bed assignment to the ETC AA and the catheterization team

PP099.02
Written 2/98

Reviewed March 1999, February 2000

Revised March 2002

Myocardial Infarction.04

Revised 4/04, 11/04

Revised 5/07

Revised 5/09

Exhibit F

Abington Memorial Hospital	Department Manual: EMERGENCY TRAUMA CENTER	Policy Number: ETC 3-68
Title: PROTOCOL ORDERS	**Category:** Patient Care	**Original Date:** 4/85
Policy Owner: ETC Director	**Keywords:** [Type Here]	**Last Review Date:** 6/04
Referenced With: [Type Here]	**Review Cycle:** Annual	**Last Revision Date:** 6/09

I. **PURPOSE:** To ensure safe, timely care to patients in the Emergency Trauma Center by implementing clinically indicated diagnostic studies based upon patient's presentation.

II. **POLICY:**

A. The ETC Professional staff may initiate specific diagnostic studies utilizing protocol orders. The protocol orders will be clearly defined and available as protocol order sets in the ED PulseCheck system.

III. **PROCEDURE:**

A. The ETC professional staff will receive an orientation to the approved protocol ordering process.

B. Protocol orders will be initiated when there are two or more charts in the physician's line-up or upon physician request.

C. Approved protocol orders are as follows:

1. Chest pain
2. Abdominal pain
3. Neurological complaints
4. Distal extremity injury
5. Pregnancy/vaginal bleeding

PP618.00

April 1985

Reviewed April 1986, Reviewed May 1987

Revised February 1988

Reviewed February 1989, Reviewed May 1991, Reviewed June 1993

Revised January 1994, Revised May 1994

Reviewed 8/95, 3/96, 5/97

Revised April 1999

Reviewed 2/00

Revised 2002

Protocol Orders.04

Revised 9/03, 6/04, 4/09, 6/09